Immunization Benefit Manual

Table of Contents

Immunization Benefit Manual

This Immunization Provider Billing Manual provides a summary of benefits and billing guidelines for Colorado Medical Assistance Program providers who administer vaccines to adults and children. The Department of Health Care Policy and Financing (the Department) periodically modifies the immunization benefits and services. Therefore, the information in this manual is subject to change, and the manual is updated as new policies are implemented.

To access the most recent fee schedule, please refer to the Provider Rates and Fee Schedules located on Department's website → For Our Providers →Provider Services → Rates and Fee Schedules.

The Colorado Medicaid Immunization benefit promotes and facilitates the prevention of vaccine-preventable diseases. The Department has an inter-agency agreement with the Colorado Department of Public Health and Environment (CDPHE) to maximize immunization recommendations by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Department of Health and Human Services.

Copies of the vaccine recommendations for the State of Colorado based on the ACIP can be found in **Appendix A** of this bulletin, and electronically on the CDPHE website.

Eligible Members

All Colorado Medicaid enrolled members are eligible for immunization services, within the following programs and limitations:

- Medicaid members, ages 18 and under, are eligible to receive all immunizations available from the federal Vaccines for Children (VFC) Program, at no cost to providers. For more information about the VFC Program, please see the "Vaccines for Children Program" section of this manual. Some immunizations have specific eligibility requirements, which are explained in the "Covered Services" section.
- Members ages 19 and older enrolled in Colorado Medicaid can receive immunizations recommended by the ACIP. Members ages 21 and older may have an office visit co-pay at the time of service.
- Members enrolled in a Colorado Medical Assistance Program Health Maintenance Organization (HMO) or Prepaid Inpatient Health Plan (PIHP) must receive immunization services through the plan's providers, not Medicaid fee-for-service providers.
- Members enrolled in the Accountable Care Collaborative (ACC) must access immunization services through their assigned primary care physician.

Covered Services

Vaccines available from the VFC Program and the Colorado Medical Assistance Program are updated annually and listed in this manual.

Refer to the Division of Disease Control and Environmental Epidemiology web page on the CDPHE website for the 2014 pediatric and adult immunization schedules, recommendations, and guidelines.

Prior Authorization

There are no prior authorization requirements except for Synagis®. Please refer to the **Prior Authorization of Synagis®** section of this manual for more information.

Immunizations for Members Ages 19 and Older

Immunizations for members ages 19 and older are a Colorado Medicaid benefit when recommended by the ACIP or when required to enter the work force or attend school. Immunizations for the sole purpose of international travel are not a benefit for Colorado Medicaid members.

The influenza vaccine is covered for members ages 21 and older one time per year. The influenza virus vaccine, live, for intranasal use (brand name FluMist, Current Procedural Terminology [CPT] code 90660) is not a benefit for adults ages 21 or older, only for members ages 2-20).

Immunizations for Members Ages 18 and Under

Immunizations for members ages 18 and under are a Colorado Medicaid benefit when recommended by the ACIP, or are required to enter the work force or to attend school. Immunizations for the sole purpose of international travel are not a benefit for Colorado Medicaid members. Immunizations may be given during an Early Periodic Screening Diagnosis and Treatment (EPSDT) periodic screening visit, an EPSDT inter-periodic visit, or any other medical appointment.

Covered CPT codes are listed in **Appendix B** of this manual. The current administration fee of $6.59 can be billed for each vaccine given. The CDPHE furnishes some vaccines to medical providers at no cost to the provider through the VFC Program [See **Appendix B** for a list of these vaccines]. The Colorado Medical Assistance Program does not reimburse for vaccines available through the VFC Program, but does reimburse for the administration fee.

Human Papilloma Virus (HPV) Vaccine

The quadrivalent HPV vaccine (CPT code 90649) administered to protect against HPV is a benefit for males and females ages 9-26 for prevention of diseases caused by HPV types 6, 11, 16, and 18. The bivalent HPV vaccine (CPT code 90650) is only a benefit for females ages 19-26. The bivalent HPV and the quadrivalent HPV vaccines are each administered in a 3-dose schedule. The HPV vaccines series should be completed with the same HPV vaccine product whenever possible.

Synagis® (palivizumab) Vaccine

Synagis® (Palivizumab) is used to prevent serious lower respiratory tract disease caused by Respiratory Syncytial Virus (RSV) in certain high risk pediatric members. The Department uses coverage criteria based on the American Academy of Pediatrics (AAP) 2014 and the Colorado Chapter of the AAP recommendations for RSV prophylactic therapy.

Limitations on Synagis®

Synagis® is administered by intramuscular injections, at 15 mg per kg of body weight, once a month during expected periods of RSV frequency in the community. Providers should be aware that the Colorado RSV season typically has a later onset, starting closer to December, and should schedule their Synagis® doses accordingly.

The 2013-2014 Synagis® season began November 15, 2013 and will end March 31, 2013. For more information, please see the October 2013 Synagis® and Influenza Vaccines Provider Bulletin (B1200329).

Seasonal Influenza Vaccine

Seasonal influenza vaccine is a benefit for children and adults, and is recommended for individuals who are six (6) months of age or older.

Free seasonal influenza vaccine is available through the Vaccines for Children (VFC) Program for all Colorado Medicaid enrolled children/adolescents (aged 18 and under).

For more Colorado Medicaid information on the seasonal influenza vaccine for both children and adults, please see the October 2013 Synagis® and Influenza Vaccines Provider Bulletin (B1200329).

Non-Covered Services and General Limitations

- The Colorado Medical Assistance Program will not reimburse providers for vaccines available through the VFC Program.
- Immunizations for the sole purpose of international travel are not a benefit for Colorado Medicaid members.
- School District providers participating in the School Health Services (SHS) Program may not bill for immunizations, because they are not covered under the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).
- ACIP recommendations for members 19 and older are subject to the Colorado Medical Assistance Program's rules.

Eligible Providers

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program member; and
- Submit claims for payment to the Colorado Medical Assistance Program.

These can include, but are not limited to:

Prescribing Provider

- Physicians
- Physician Assistants
- Advanced Practice Nurse
- Nurse
- Local Public Health Agencies (LPHAs)

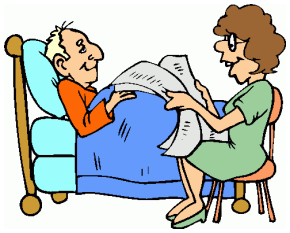
Rendering Provider

- Physician
- Physician Assistant
- Advanced Practice Nurse
- Nurse
- Public Health Agencies
- Rural Health Centers (RHC)
- Federally Qualified Health Centers (FQHC)
- Hospitals
- Clinics

- School-Based Health Centers (SBHC)
- Pharmacists are not eligible providers.

Eligible Places of Service

- Local Public Health Agencies (LPHA)
- Rural Health Centers (RHC)
- Federally Qualified Health Centers (FQHC)
- Hospitals
- Clinics
- School Based Health Centers (SBHC)
- Office



- For members residing in a facility or receiving home health services:
- Nursing Facilities – residents may receive immunizations if ordered by their physician. The skilled nursing component for immunization administration is included in the facility's rate. The vaccine itself may be billed directly to the Colorado Medical Assistance Program by a Colorado Medical Assistance Program enrolled pharmacy. The pharmacy must bill the appropriate National Drug Code (NDC) for the individual vaccine dose under the member's Colorado Medical Assistance Program ID.
- Home Health – a member confined to the home and receiving home health services may receive an immunization if the administration is part of a normally scheduled home health visit. A home health visit for the sole purpose of immunization administration is not a benefit. The pharmacy bills the vaccine as an individual dose under the member's Colorado Medical Assistance Program ID. The home health agency may not bill for the vaccine.
- Alternative Health Care Facilities (ACFs)/Group Homes – residents of an ACF may receive immunizations from their own physician. They may also receive vaccines under home health as stated above in the home health guideline.
- The Colorado Medical Assistance Program does not pay for home health agencies, physicians, or other non-physician practitioners to go to nursing facilities, group homes, or residential treatment centers to administer immunizations (for example: flu vaccines) to groups of members.

Note: Pharmacies are not an eligible place of service.

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests for paper claim submission may be sent to the Department's fiscal agent, Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090.
The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit five (5) claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/) (HIPAA EDI Technical Report 3 (TR3))
- Companion Guides for the 837P, 837I, or 837D in the Provider Services Specifications section of the Department's website.
- Web Portal User Guide (via the portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system. For additional electronic information, please refer to the Medicaid Provider Information manual located on the Department's website (Colorado.gov/hcpf) → For Our Providers → Provider Services → Billing Manuals.

Billing for Members Ages 18 and Under

Providers must use CPT procedure codes to submit all immunization claims. For additional billing information for Synagis® and the Influenza Vaccine, see the "Synagis®" and "Influenza Vaccine" sections above.

Members ages 0-18 may receive vaccines at no cost through the VFC Program, a CDPHE managed federally-funded program. For providers to receive federally-funded vaccines to administer to their Medicaid members (ages 0-18), they must be enrolled in the VFC Program. Vaccines available through the VFC Program are not reimbursed by the Colorado Medical Assistance Program. However, an administration fee can be billed in conjunction with each vaccine given. For more information on the administration billing codes and the current administration billing code reimbursement rate, please see the "Reimbursement Rate" section of this manual.

Providers may bill for immunizations given during an EPSDT periodic screening appointment, an EPSDT inter-periodic visit, or any other medical appointment

- If immunizations are given during an EPSDT periodic screening appointment or during any other medical care appointment (also called an "EPSDT inter-periodic visit"), claims must be submitted on the CMS 1500 paper claim form or as an 837 Professional (837P) electronic transaction using the appropriate procedure and diagnosis codes. For an example of the CMS 1500 paper claim form, please see the claim example at the end of this manual. Practitioners must maintain records that document the full nature and extent of the services rendered during this visit.

- If an immunization is the only service provided to a Colorado Medicaid member ages 18 and under, the service must be billed on the CMS 1500 paper claim form or as an 837P electronic transaction with the appropriate procedure and diagnosis codes.

Billing for Members Ages 19 and Over

The Colorado Medical Assistance Program reimburses for both vaccine administration and the vaccine product itself for members ages 19 and over. Administration codes 90471-90474 must be billed as one line item and the vaccine product should be billed as a separate line item. Providers must bill both an administration code and the product code in order to be reimbursed. See the "Reimbursement Rate" section of this manual for vaccine administration rates.

Providers must submit claims for adult immunization services on the CMS 1500 paper claim form or as an 837P electronic transaction. Please refer to bottom of the Provider Services home page on the Department's website for the current fee schedule.

If an immunization is the only service rendered, providers may not submit charges for an Evaluation/Management (E/M) service.

If E/M services are rendered in addition to the immunization administration by an appropriate provider, enter the diagnosis and appropriate procedure codes on the claim.

Billing for Synagis®

- The Department will provide pricing information during each Synagis® season.
- Providers may not ask members to obtain Synagis® from a pharmacy and bring it to the practitioner's office for administration.
- Synagis® given in a doctor's office, hospital, or dialysis unit is to be billed directly by those facilities as a medical benefit. **Synagis® may only be a pharmacy benefit if the medication is administered in the member's home or long-term care facility.**

Note: A separate Synagis® PAR process exists for the CHP+ State Managed Care Network members. Any questions regarding this process should be directed to Colorado Access at 303-751-9005 or 1-800-511-5010, or US Bioservices at 303-706-0053.For additional questions, please contact Meredith Henry at 303-866-4538 or Meredith.Henry@state.co.us. You may also contact Richard Delaney at 303-866-3436 or Richard.Delaney@state.co.us.

Billing for the Influenza Vaccine

Use the following CPT codes when billing for the influenza vaccine. For members 18 and under, seasonal influenza vaccine reimbursement is limited to the current administration fee of $6.59. For members ages 18 and under, reimbursement for the actual influenza vaccine is $0 because the vaccines are available at no cost through the VFC Program. In these cases, providers will be reimbursed only the vaccine administration fee.

CPT Code	Valid Ages	Reimbursement for members (18 and under)	Reimbursement for members (19 and older)	Administration reimbursement
90655	2 and under	$0	Not a benefit	$6.59
90656	3 years and older	$0	$17.44	$6. 59
90657	2 and under	$0	Not a benefit	$6. 59
90658	3 years and older	$0	$13.74	$6. 59
90660	2-20 years	$0	$20.58	$6. 59

CPT Code	Valid Ages	Reimbursement for members (18 and under)	Reimbursement for members (19 and older)	Administration reimbursement
90661	All Ages	$0	$14.40	$6.59

CPT codes 90460, 90461, and 90471-90474 for vaccine administration are a benefit and may be billed in conjunction with the vaccine code.

Vaccine administration codes 90460 and 90471-90474 are currently reimbursed at $6.59. Immunization administration add-on code for each vaccine component in a given vaccine, 90461, will be reimbursed at $0.

Billing Instructions for Specific Providers

Managed Care Programs

Colorado Medicaid members enrolled in Health Maintenance Organization (HMO) or Prepaid Inpatient Health Plan (PIHP) must receive immunization services from the HMO or PIHP, and providers may not bill the Colorado Medical Assistance Program directly for vaccines provided to these members.

Outpatient, Emergency Room, or Inpatient Hospital

Immunization administration may be billed as part of an outpatient or emergency room visit when the visit is for medical reasons.

Outpatient or emergency room visits cannot be billed for the sole purpose of immunization administration. Administration of an immunization at the time of an inpatient stay is included in the APR-DRG.

Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)

FQHCs and RHCs may bill an encounter fee even if the only service provided is administering an immunization. If an immunization is administered in addition to a routine office visit, then an additional encounter fee may not be billed.

Nursing Facilities

Nursing facility residents may receive immunizations if ordered by their physician. The skilled nursing component for immunization administration is included in the facility's rate. The vaccine itself may be billed directly to the Colorado Medical Assistance Program by a Colorado Medical Assistance Program enrolled pharmacy. The pharmacy must bill the appropriate National Drug Code (NDC) for the individual vaccine dose under the member's Colorado Medical Assistance Program ID.

Home Health

A member receiving home health services may receive immunizations if the administration is part of a normally scheduled home health visit. A home health visit for the sole purpose of immunization administration is not a benefit.

The pharmacy bills the vaccine as an individual dose under the member's Colorado Medical Assistance Program ID. The home health agency may not bill for the vaccine.

Alternative Health Care Facilities (ACFs)/Group Homes

Residents of an ACF may receive immunizations from their own physician. They may also receive vaccines under home health as stated above in the home health guideline.

The Colorado Medical Assistance Program does not pay for home health agencies, physicians, or other non-physician practitioners to go to nursing facilities, group homes, or residential treatment centers to administer immunizations (for example: flu vaccines) to groups of members.

Medicare Crossover Claims (Medicare/Medicaid Claims)

For Medicare crossover claims, the Colorado Medical Assistance Program pays the Medicare deductible and coinsurance or Colorado Medical Assistance Program allowable reimbursement minus the Medicare payment, whichever amount is less. If Medicare's payment for immunization services is the same or greater than the Colorado Medical Assistance Program allowable benefit, no additional payment is made.

If Medicare pays 100 percent of the Medicare allowable, the Colorado Medical Assistance Program makes no additional payment.

Immunization Billing Codes

Please see **Appendix B** of this manual.

National Correct Coding Initiative (NCCI) Impacts on Immunization and Evaluation & Management (E&M) Codes

Effective April 1, 2014, the Department will no longer reimburse NCCI procedure-to-procedure (PTP) edits when immunization administration procedure codes (CPT 90460-90474) are paired with preventative medicine E&M service procedure codes (CPT 99381-99397).

If a significant separately identifiable E&M service (e.g. new or established patient office or other outpatient services [99201-99215], office or other outpatient consultation [99241-99245], emergency department service [99281-99285], preventative medicine service [99381-99429] is performed), the appropriate E&M service code should be reported in addition to the vaccine and toxoid administration codes.

Each NCCI PTP edit has an assigned modifier indicator. A modifier indicator of "0" indicates that NCCI PTP-associated modifiers cannot be used to bypass the edit. A modifier indicator of "1" indicates that NCCI PTP-associated modifiers may be used to bypass an edit under appropriate circumstances. A modifier indicator of "9" indicates that the edit has been deleted, and the modifier indicator is not relevant. The Correct Coding Modifier Indicator can be found in the files containing Medicaid NCCI PTP edits on the CMS website.

A modifier should not be added to a HCPCS/CPT code solely to bypass an NCCI PTP edit, if the clinical circumstances do not justify its use. If the E&M service is significant and separately identifiable and performed on the same day, the E&M code should be billed with the vaccine and toxoid administration codes using PTP associated modifier 25. Modifier 25 is only valid when appended to the E&M codes. Do not append to the immunization administration procedure codes 90460-90474.

Counseling and Behavioral Change Intervention Billing Clarification

Pursuant to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) editing, preventive medicine counseling codes and behavior change intervention codes will no longer be reimbursed by the Department when billed in conjunction with vaccine/immunization administration codes (90460-90474) unless it is appropriate in each individual circumstance to append the NCCI modifier. The preventive medicine counseling/behavior change intervention codes subject to this policy include, among others,

- 99401-individual preventive medicine counseling; 15 minutes,
- 99402-individual preventive medicine counseling; 30 minutes, and
- 99420-administration and interpretation of a health risk assessment instrument – used for adolescent depression screening.

When using a modifier is appropriate, refer to the CMS NCCI Policy Manual, Chapter 1, section E for specific guidance on proper use of modifiers.

Pediatric Immunization Codes 90460 and 90461

In the January 2011 Immunization Provider Bulletin (B1100293), the Department published instructions on how to bill the new pediatric immunization administration codes 90460 and 90461. These two codes replaced codes 90465, 90466, 90467, and 90468 which were deleted as of January 1, 2011.

Since that bulletin, the Department has received numerous inquiries on how to properly bill these new codes, and is now issuing the following clarification.

The pediatric immunization administration codes 90460 and 90461 are component based and replace deleted codes 90465-90468. These new codes allow the provider to bill for each vaccine component separately.

As defined by the 2011 CPT, a vaccine component is each antigen in the vaccine that prevents disease(s) caused by one organism.

CPT codes 90460 and 90461 reflect the administration of one component vaccines, which provide protection for a single disease, and multiple component vaccines (combination vaccines), which provide protection for multiple diseases. These codes must be reported for Colorado Medicaid members ages 0-18 and when a physician or qualified health care professional provides face-to-face counseling to the member and family during the administration of a vaccine.

The following chart identifies the number of components in some of the common pediatric vaccines, and how to report the pediatric immunization administration codes for each vaccine:

Table 1

Vaccine	# of Components	Which Codes to Report?
HPV	1	90460
Influenza	1	90460
Meningococcal	1	90460
Pneumococcal	1	90460
Td	2	90460, 90461
DTaP or Tdap	3	90460, 90461, 90461
MMR	3	90460, 90461, 90461
DTaP-Hib-IPV	5	90460, 90461, 90461, 90461, 90461
DTaP-HepB-IPV	5	90460, 90461, 90461, 90461, 90461
DTaP-IPV	4	90460, 90461, 90461, 90461
MMRV	4	90460, 90461, 90461, 90461
DTaP-Hib	4	90460, 90461, 90461, 90461
HepB-Hib	2	90460, 90461
Rotavirus	1	90460
IPV	1	90460
Hib	1	90460

Source: American Academy of Pediatrics "FAQ Fact Sheet for the 2011 Pediatric Immunization Administration Codes"

To submit claims for immunization services, providers must "roll up/bundle" the total unit count of the immunization administration codes.

- If an immunization administration code is billed for each vaccine that was given during the visit as its own line item, each subsequent line item billed using 90460 after the initial 90460 line item will be denied as a duplicate claim.

Example 1:

The following example, demonstrates how to bill for the administration of Hep A, DTaP-HIB-IPV, and MMR vaccines.

Component Calculation and which codes to report (Using Table 1):

Table 2

Vaccine	# of Components	Which Codes to Report?
Hep A	1	90460
DTaP-HIB-IPV	5	90460, 90461, 90461, 90461, 90461
MMR	3	90460, 90461, 90461

How to Bill:

Table 3

Line #	CPT Descriptor	CPT Code	Units
Line 1	First Vaccine Component	90460	3
Line 2	Additional Vaccine Component	90461	6
Line 3	Hep A	90633	1
Line 4	DTaP-HIB-IPV	90698	1
Line 5	MMR	90707	1

- CPT code 90460 is billed for 3 units because it was reported once for each vaccine that was administered.
- CPT code 90461 is billed for 6 units because it was reported 6 times (4 times for the DTaP-HIB-IPV vaccine and 2 times the MMR vaccine).

For further clarification on billing pediatric immunization codes, please refer to the American Academy of Pediatrics (AAP) practice guidelines.

For billing questions, please contact the Department's fiscal agent, Xerox State Healthcare at 1-800-237-0757 or 1-800-237-0044. For all other inquiries, please contact Meredith Henry at Meredith.Henry@state.co.us or 303 866 4538

Vaccine Administration Codes 90471-90474

The Colorado Medical Assistance Program will reimburse for both vaccine administration and the vaccine product itself (ages 19 and older).

The immunization administration codes 90471-90474 need to be billed as one line item, and the vaccine product should be billed as a separate line item. In order for an immunization claim to be reimbursed both an administration code and the vaccine product must be billed. For the current reimbursement rate for administration codes 90471-90474, please refer to the Provider Services home page on the Department's website for the current fee schedule. If an immunization is the only service rendered, providers may not submit charges for an E/M service.

Adult immunizations are reimbursed at the lower billed charges or the Medicaid fee schedule amount for each immunization.

Note: Providers are not to bill CPT codes 90471-90474 for children ages 0-18 for whom counseling was given (see section "Pediatric Immunization Codes 90460 and 90461" in this manual). CPT Codes 90471-90474 must only be billed for members (ages 19 and older) or members ages 18 and under for whom no counseling was given.

Preventive Medicine Counseling Codes 99401, 99402, and 99211

If a member receives only immunization-related counseling during the visit, the provider may not bill a preventive medicine counseling code, and may only bill the vaccine administration fee. However, if the member receives other prevention counseling (besides the immunizations) such as child health, developmental milestones, sexually transmitted infection safety, etc., the provider may bill the following codes:

- 99401 – Approximately 15 minutes of counseling
- 99402 – Approximately 30 minutes of counseling
- 99211 – Approximately 5 minutes of counseling (for examples, please see Appendix B – Clinical Examples in the AMA CPT billing manual)

Keep documentation in the member's chart that shows the duration of counseling and a list of the prevention topics covered during counseling.

Reimbursement Rates

The current immunization administration rate is $6.50 per vaccine rendered. Please always refer to the fee schedule on the Provider Services section of the Department's website for the most up-to-date rate information.

Immunizations for Members Ages 18 and Under

If the vaccine is not available through the VFC Program, providers are reimbursed at the lower of billed charges or the Medicaid fee schedule amount for each immunization.

If the vaccine is available through the VFC Program, the Colorado Medical Assistance Program pays providers only an administration fee for immunizations. Because the vaccine is available at no cost through this program, providers who choose to obtain vaccines from other suppliers may not request nor receive reimbursement from the Colorado Medical Assistance Program for the vaccine. Vaccines available from VFC Program and the CIP are shown in **Appendix B** of this manual.

Immunizations for Members Ages 19 and Older

Adult immunizations are reimbursed at the lower of billed charges or the Medicaid fee schedule amount for each immunization.

Colorado Department of Public Health and Environment (CDPHE) Vaccine Programs

This section contains information about the CDPHE vaccine program, the VFC Program, in which the Colorado Medical Assistance Program participates in.

Participation in the VFC Program is strongly encouraged by the Department. Providers, including but not limited to private practitioners, managed care providers, public health agencies, Rural Health Centers (RHCs), hospital outpatient clinics, and Federally Qualified Health Centers (FQHCs), who wish to participate in the immunization program must enroll with the CDPHE. Providers can get information on how to enroll by calling 303-692-2650.

Under this program, providers are required to give members the federally required "Important Information Statement" or, for vaccines covered by the national Vaccine Injury Compensation Program, the appropriate "Vaccine Information Statement." These statements may be downloaded from the Centers for Disease Control and Prevention (CDC) website.

Vaccines for Children (VFC) Program

First created in 1993, the VFC program is a State-operated and federally-funded vaccine supply program that is managed in Colorado by the CDPHE's Immunization Section.

The purpose of the program is to help elevate the number of children receiving immunizations across the United States, providing free routine vaccines to eligible children at no cost to participating providers. Routine vaccines are defined as those recommended by the ACIP.

Many children across the United States are not vaccinated because of a lack of access for reasons such as their parents not having health insurance. The VFC Program removes any barriers for eligible children to get vaccinated.

✱ What the VFC Program Guarantees:

- A supply of federally purchased vaccine to be administered to eligible children at no cost to any public health care provider and private health care provider who are participating in the VFC Program.
- Purchase and supply to participating providers in all fifty states, territories, and Washington, D.C.

✱ Who is Eligible:

- Children ages 0-18, who also meet one of the following criteria:
- Medicaid eligible;
- Uninsured;
- Covered by the Colorado Indigent Care Program (CICP)
- American Indian or Alaskan Native (even if they have full or partial insurance that covers vaccines they are still eligible to receive VFC vaccines), or;
- Underinsured (these members may only receive VFC vaccines at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs).

✱ Who is NOT Eligible:

- Children ages 0-18, who also meet one of the following criteria:
- Underinsured and seen in a private physician's office (these children should be referred to either a public health clinic or community health center to receive VFC vaccinations);

- Are covered by the Colorado Child Health Plan Plus (*CHP+)*;
- Have health insurance, but whose insurance covers only a percentage of the cost of one or more vaccines, are still considered insured and therefore not eligible for the VFC program.

✱ How to Enroll as a Provider:

- Contact CDPHE at 303-692-2650.
- Request a provider enrollment packet, which lists the requirements for participation. Read and complete the entire enrollment packet which includes:
- Form 1: New Provider Enrollment Form
- Form 2: Prescriber List
- Form 3: New Provider Profile Form
- Form 4: Provider Enrollment Agreement

- Return all required forms and information to:

  Colorado Department of Public Health & Environment
  Immunization Program – DCEED-IMM A3
  4300 Cherry Creek Drive South
  Denver, CO 80246

- Or fax the required forms and information to: 303-691-6118

✱ For questions and/or more information:

- Please see **Appendix C** of this manual**.**
- Please visit the Frequently Asked Questions (FAQ) page on the CDPHE website, or please see the attached FAQ page in **Appendix C** of this manual. Questions may also be directed to Deb Zambrano, RN, BSN at CDPHE at Deb.Zambrano@state.co.us or 303-692-2258.

✱ Current Vaccines Provided to the VFC Program Enrolled Providers:

Vaccine Type	Vaccine Name	Age Range	Comments
DT		6 weeks-6 years	Special order only
DTaP	Infanrix	6 weeks-6 years	Licensed for primary series and doses 4 and 5
	Daptacel	6 weeks-6 years	Primary series and dose 4
Dtap-IPV-HepB	Pediarix	6 weeks-6 years	Primary series only (doses 1,2,3 only)
Dtap-IPV-Hib	Pentacel	6 weeks-3 years	Doses 1,2,3,4 only

Vaccine Type	Vaccine Name	Age Range	Comments
DTaP-IPV	Kinrix	4 years- 6 years	Dose 5 only
e-IPV	IPOL	6 weeks- 18 years	
Hep A pediatric/adoles.	Vaqta	12 months-18 years	
	Havrix	12 months-18 years	
Hep B pediatric/adoles.	Recombivax HB	Birth- 18 years	
	Engerix-B	Birth- 18 years	
Hib	ActHib	2 months- 4 years	
	PedvaxHib	6 weeks- 4 years	
HPV	Gardasil	9 years-18 years	Male and female
Influenza Vaccines	Flu-Mist	2 years-18 years	
	Fluzone	6 months-18 years	
	Fluzone-Pediatric	6-35 months	
	Fluzone-Preservative free	Age 36 months-18 years	
	Fluarix-Preservative free	Age 36 months-18 years	
	Fluvirin	Age 4 years- 18 years	

Vaccine Type	Vaccine Name	Age Range	Comments
	FluLaval	3 years and older	
Meningococcal	Menactra	2 years-18years	
	Menveo	2 years-18 years	
Pneumococcal conjugate	Prevnar 13	2 months-59 months	May be given up to all ages, if high risk or immune compromised
Pneumococcal polysaccharide	PneumovaxP	2 years-18 years	High risk only/special order
Rotavirus	Rotateq	6 weeks-32 weeks	
	Rotarix	6 weeks-32 weeks	
Tdap	Adacel	11 years-18 years	
	Boostrix	10 years-18 years	May be given as young as age 7 if no previous doses of DTaP given
Td	Tenivac	7 years –18 years	
Measles-Mumps-Rubella	MMR	12 months-18 years	
Varicella	Varivax	12 months-18 years	
MMR-V	Proquad	12 months-12 years	

Colorado Immunization Program (CIP)

As of January 1, 2013, the CIP no longer provides vaccines to providers for Colorado Medicaid members who are 19 and 20 years of age. Immunizations for members ages 19 and older (instead of ages 21 and older) are now a Colorado Medicaid benefit when recommended by the ACIP, and are reimbursed for by Colorado Medicaid. For more information, please see the December 2012 Provider Bulletin (B1200331).

Vaccine Information Statements

1. **Provide a Vaccine Information Statement (VIS) when a vaccination is given.**

   As required under the National Childhood Vaccine Injury Act (42 U.S.C. §300aa-26), all health care providers in the United States who administer, to any child or adult, any of the following vaccines – diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, hepatitis A, hepatitis B, *Haemophilus*

influenzae type b (Hib), trivalent influenza, pneumococcal conjugate, meningococcal, rotavirus, human papillomavirus (HPV), or varicella (chickenpox) – shall, prior to administration of each dose of the vaccine, provide a copy to keep of the relevant current edition vaccine information materials that have been produced by the Centers for Disease Control and Prevention (CDC):

- To the parent or legal representative* of any child to whom the provider intends to administer such vaccine,
- To any adult† to whom the provider intends to administer such vaccine.

> *"Legal representative" is defined as a parent or other individual who is qualified under State law to consent to the immunization of a minor child or incompetent adult.
>
> † In the case of an incompetent adult, relevant VISs shall be provided to the individual's legal representative. If the incompetent adult is living in a long-term care facility, all relevant VISs may be provided at the time of admission, or at the time of consent if later than admission, rather than prior to each vaccination.

2. Record information for each VIS provided.

Health care providers shall make a notation in each member's permanent medical record at the time vaccine information materials are provided, indicating:

(1) The edition date of the Vaccine Information Statement distributed, and

(2) The date the VIS was provided.

This recordkeeping requirement supplements the requirement of 42 U.S.C. §300aa-25 that all health care providers administering these vaccines must record in the member's permanent medical record (or in a permanent office log):

(3) The name, address and title of the individual who administers the vaccine,

(4) The date of administration, and

(5) The vaccine manufacturer and lot number of the vaccine used.

These statements may be downloaded from the Centers for Disease Control and Prevention (CDC) website.

Colorado Immunization Information System (CIIS)

In collaboration with CDPHE, the Colorado Medical Assistance Program provides data to the CIIS on a weekly basis for eligible members enrolled in Medicaid, ages 20 and under and immunization-related claims for members ages 20 and under at the date of service.

The Colorado Medical Assistance Program provides information to individuals, parents or guardians as required by C.R.S. § 25-4-2403 (7) on how the individual, parent, or guardian can choose to have their (or their child's) immunization information excluded from CIIS. CIIS is a core component of the State's public health infrastructure and an important part of a larger strategy designed to support immunization of Colorado residents, ensure the prevention of vaccine-preventable disease, and reduce health care costs to individuals and the State.

CIIS, the State's immunization registry, is a confidential, computerized, population-based system that collects and consolidates vaccination data for Coloradans of all ages and provides tools for designing and sustaining effective immunization strategies at the provider and program levels.

At the provider level, CIIS offers decision support at the point of clinical care to all participating providers by forecasting needed vaccinations, providing consolidated immunization histories regardless of whether a member has received immunizations from multiple providers, generating vaccination coverage reports,

member reminders, or recalls for members overdue for vaccinations, thus serving as a centralized method to ensure appropriate and timely vaccinations. Additionally, CIIS provides functionality to assist providers in managing their public and private vaccine inventory, allowing for a simple mechanism to facilitate vaccine management and ensure accountability with publically funded vaccines.

At the population level, CIIS provides aggregate data and generates vaccination coverage reports for surveillance, epidemiological investigations, and program operations to inform public health activities with the goals of improving vaccination rates and reducing vaccine-preventable disease.

CIIS is a critical tool to facilitate the appropriate usage of limited public funds that support immunizing our most vulnerable populations by ensuring that Coloradans are appropriately immunized with the correct vaccinations on time. By participating in CIIS, healthcare professionals, parents and individuals can rest assured that their immunization records are safe and complete. The Department strongly encourages all providers to participate in the CIIS. For more information, please contact the CIIS Coordinator in the appropriate county.

Definitions

Colorado Immunization Information System (CIIS): CIIS, the State's immunization registry, is a confidential, computerized, population-based system that collects and consolidates vaccination data for Coloradans of all ages and provides tools for designing and sustaining effective immunization strategies at the provider and program levels.

Component: a component refers to all antigens in a vaccine that prevents disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple vaccine components. Ref: American Academy of Pediatrics "FAQ Fact Sheet for the 2011 Pediatric Immunization Administration Codes"

Scope of Practice: Terminology that is used by State licensing boards for various professions to define the procedures, actions, and processes that are permitted for a licensed individual. It defines the level of medical responsibility and/or health services (boundaries within which a health care provider may practice) and/or range of activities that a practitioner is legally authorized to perform independently or with supervision based on their specific education and experience. Ref: American Academy of Pediatrics "FAQ Fact Sheet for the 2011 Pediatric Immunization Administration Codes"

Vaccines for Children (VFC) Program: The purpose of the program is to help elevate the level of children receiving immunizations across the United States, providing free routine vaccines to eligible children at no cost to active enrolled providers. Routine vaccines are defined as those recommended by the ACIP.

Many children across the United States are not vaccinated because of a lack of access for reasons such as their parents not having health insurance. The VFC Program removes any barriers for eligible children to get vaccinated.

CMS 1500 Paper Claim Reference Table

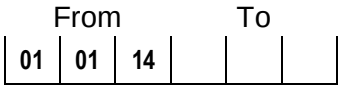
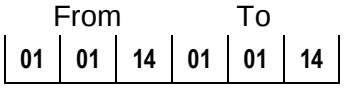
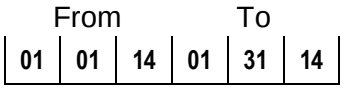
The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the CMS 1500 paper claim form.

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
5	**Patient's Address**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
6	**Patient's Relationship to Insured**	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Conditional	If field 11d is marked "YES", enter the insured's last name, first name and middle initial.
9a	**Other Insured's Policy or Group Number**	Conditional	If field 11d is marked "YES", enter the policy or group number.
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Conditional	If field 11d is marked "YES", enter the insurance plan or program name.
10a-c	**Is Patient's Condition Related to?**	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.

CMS Field #	Field Label	Field is?	Instructions
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Conditional	When appropriate, place an "X" in the correct box. If marked "YES", complete 9, 9a and 9d.
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Conditional	Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
	in Current Occupation		
17	**Name of Referring Physician**	Not Required	
18	**Hospitalization Dates Related to Current Service**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.
20	**Outside Lab?** **$ Charges**	Conditional	Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim

CMS Field #	Field Label	Field is?	Instructions
			This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Not Required	
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014  Or  Span dates of service  Practitioner claims must be consecutive days. Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier**

CMS Field #	Field Label	Field is?	Instructions
			To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code N4 National Drug Codes VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. 03 School 04 Homeless Shelter 05 IHS Free-Standing Facility 06 Provider-Based Facility 07 Tribal 638 Free-Standing 08 Tribal 638 Provider-Based 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 24 ASC 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice

CMS Field #	Field Label	Field is?	Instructions
			41 Transportation – Land 42 Transportation – Air or Water 50 Federally Qualified Health Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 55 Residential Treatment Facility 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 72 Rural Health Clinic 81 Independent Lab 99 Other Unlisted
24C	**EMG**	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.

CMS Field #	Field Label	Field is?	Instructions
24D	**Modifier**	Not Required	
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.

CMS Field #	Field Label	Field is?	Instructions
24G	**Days or Units**	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Colorado Medical Assistance Program bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units.
24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used **Family Planning** (unshaded area) If the service is Family Planning, enter "Y" for YES or "N" for NO in the bottom, unshaded area of the field**.**
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic. NOTE: When billing a paper claim form, do not use the individual's NPI.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).

CMS Field #	Field Label	Field is?	Instructions
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Name

CMS Field #	Field Label	Field is?	Instructions
	32a- NPI Number **32b- Other ID #**		2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known). 32b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known). The information in field 32, 32a and 32b is not edited.
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

CMS 1500 Immunization Claim Example

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE: MM 10 DD 16 YY 45 | SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X | If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File | DATE: 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. V82.9 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 15	01 01 15	11		90656			A	17 44	1		NPI	12345678 / 0123456789
2	01 01 15	01 01 15	11		90471			A	6 33	1		NPI	12345678 / 0123456789
3												NPI	
4												NPI	
5												NPI	
6												NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X | NO

28. TOTAL CHARGE $ 23 77

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature | DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. | b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Clinic
100 Any Street
Any City

a. 1234567890 | b. 04567890

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the "Claim Notes/LBOD" field.

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules

11 Other

The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services Billing Manuals section of the Department's website.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to a fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: Occurrence code 53 and the date are required in FL 31-34. ➢ *CMS 1500*: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➢ *2006 ADA Dental*: Indicate "LBOD" and the date in box 35 - Remarks
Adjusting Paid Claims	If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider. **Adjust the claim within 60 days** of the claim payment. Retain all documents that prove compliance with timely filing requirements. *Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.* **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.

Billing Instruction Detail	Instructions
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied. **Correct the claim errors and refile within 60 days** of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements. **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.
Returned Paper Claims	A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information. **Correct the claim errors and re-file within 60 days** of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent. **LBOD** = the stamped fiscal agent date on the returned claim.
Rejected Electronic Claims	An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection. **Correct claim errors and refile within 60 days** of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection. **LBOD** = the date shown on the claim rejection report.
Denied/Rejected Due to Member Eligibility	An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility. **File the claim within 60 days** of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection. **LBOD** = the date shown on the eligibility rejection report.
Retroactive Member Eligibility	The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that: • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.

Billing Instruction Detail	Instructions
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Certification & Request for Timely Filing Extension in the Provider Services Forms section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification. • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. **LBOD** = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.
Electronic Medicare Crossover Claims	An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.) **File the claim within 120 days** of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Medicare Denied Services	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial. *Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.* **File the claim within 60 days** of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance. **File the claim within 60 days** of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial

Billing Instruction Detail	Instructions
	insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. **File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

Appendices

Appendix A - Immunization Schedules

- Recommended Immunization schedule for persons aged 0 through 18 years.
- Recommended Immunization schedule for adults.

Appendix B

Immunization Coding Quick Reference		
Practitioners billing for immunizations provided to Colorado Medicaid enrolled children, ages 18 and under when vaccine is available at no-cost through the VFC Program, are paid only an administration fee for each immunization using CPT codes 90460 and 90471 – 90474. The immunization administration add-on code for each additional vaccine component in a given vaccine, 90461, is paid an administration fee of zero (0). Medically necessary vaccines for member's ages 20 that are not available through the VFC Program are reimbursed at the lower of billed charges or Medicaid fee schedule for each immunization. Reimbursement is subject to change. Please refer to the bottom of the Provider Services home page on the Department's website for the current fee schedule.		
Key		
Ig – immune globulin IM – intramuscular	INJ – jet injection IV – intravenous	SQ – subcutaneous vacc – vaccine

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
Immune Globulins				
90281	Human Ig, IM	All ages	$15.03	
90283	Human Ig, IV	All ages	$263.27	
90284	Human Ig, SQ	All ages	$592.75	
90287	Botulinum antitoxin, equine	All ages	$196.99	
90288	Botulism Ig, IV	All ages	$462.64	
90291	CMV Ig, IV	All ages	$367.24	
90296	Diphtheria antitoxin, equine	All ages	$41.46	
90371	Hep B Ig, IM	All ages	$168.88	
90375	Rabies Ig, IM/SQ	All ages	$97.14	
90376	Rabies Ig, heat-treated, IM/SQ	All ages	$96.10	
90378	RSV Ig, IM, 50mg (Synagis®)	0-3	$1,372.74	
90384	Rh Ig, full-dose, IM	All ages	$115.69	
90385	Rh Ig, mini-dose, IM	All ages	$52.66	
90386	Rh Ig, IV	All ages	$131.80	
90389	Tetanus Ig, IM	All ages	$114.25	

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
90393	Vaccinia Ig, IM	All ages	$116.49	
90396	Varicella-zoster Ig, IM	All ages	$110.66	
90399	Unlisted immune globulin	All ages	$57.26	

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
Vaccines, Toxoids				
90476	Adenovirus vacc, type 4, oral	All Ages	$35.08	
90477	Adenovirus vacc, type 7, oral	All ages	$35.08	
90632	Hep A vacc, adult, IM	19+	$79.20	
90633	Hep A vacc, ped/adol, 2 dose, IM	0-18	$0	√
90636	Hep A & Hep B vacc adult, IM	18+	$106.11	
90645	Hib vacc HbOC, 4 dose, IM	0-4	$0	√
90647	Hib vacc, PRP-OMP, 3 dose, IM	0-4	$0	√
90648	Hib-PRP-T	2 months-5 years	$0	√
90649	HPV vacc types 6,11,16,18 quadrivalent 3 dose, IM	9-18	$0	√
		19-26	$159.96	
90650	HPV vacc types 16, 18 bivalent 3 dose, IM	19-26, female only	$159.96	
90654	Influenza virus vaccine, split virus, preservative free, for intradermal use	19+	$18.75	
90655	Flu vacc, 6-35 mo, preserv free, IM	0-2	$0	√
90656	Flu vacc, 3 yrs +, preserv free, IM	3-18	$0	√
		19+	$17.79	
90657	Flu vacc, 6-35 mo, IM	0-2	$0	√
90658	Flu vacc, 3 yrs +, IM	3-18	$0	√
		19+	$14.01	
90660	Flu vacc, live, intranasal	2-18	$0	√
		19-20	$20.99	
90661	Flu vacc, egg free, preserv free	0-18	$0	√

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
		19+	$14.40	√
90669	Pneum conj vacc, polyval, < 5 yrs, IM	0-4	$0	√
90670	Pneumococcal Conj Vacc, 13 Valent, IM	0-18	$0	√
		19+, w/ Immune health issue	$152.01	
90672	Influenza vaccine for nasal administration	0-2	$0	√
		21+	$21.36	
90675	Rabies vacc, IM	All ages	$193.12	
90680	Rotavirus vacc, pentavalent, oral	0-1	$0	√
90681	Rotavirus vacc, attenuated, oral	0-1	$0	√
90686	Influenza virus vacc, quadrivalent, split virus, preservative free, 3 yrs +, IM	3-18	$0	√
		19+	$15.45	
90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use	3-18	$0	√
		19+	$15.76	
90696	D Tap-IPV vacc, IM	4-6	$0	√
90698	DTaP – Hib – IPV vacc, IM	0-4	$0	√
90700	DTaP vacc, < 7 yrs, IM	0-6	$0	√
90702	DT vacc, < 7 yrs, IM	0-6	$0	√
90703	Tetanus vacc, IM	All ages	$52.87	
90704	Mumps vacc, SQ	All ages	$29.93	
90705	Measles vacc, SQ	All ages	$23.56	
90706	Rubella vacc, SQ	All ages	$26.02	
90707	MMR vacc, SQ	0-18	$0	√
		19+	$53.42	

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
90708	Measles-rubella vacc, SQ	All ages	$28.57	

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
90710	MMRV vacc, SQ	1-12	$0	√
90713	Poliovirus vacc, IPV, SQ, IM	0-18	$0	√
		19+	$63.80	
90714	Td vacc, 7 yrs +, preserv free, IM	7-18	$0	√
		19+	$51.54	
90715	Tdap vacc, 7 yrs +, IM	7-18	$0	√
		19+	$97.26	
90716	Varicella (chicken pox) vacc, SQ	0-18	$0	√
		19+	$102.47	
90718	Td vacc, 7 yrs +, IM	7-18	$0	√
		19+	$28.82	
90719	Diphtheria vacc, IM	All ages	$10.46	
90721	DTaP/Hib vacc, IM	0-6	$0	√
90723	DTaP-Hep B-IPV vacc, IM	0-6	$0	√
90732	Pneum polysacc vacc, 23 valent, adult or ill pat, SQ/IM	2-18	$0	√
		19+	$76.33	
90733	Meningococcal polysacc vacc, SQ	All ages	$118.54	
90734	Meningococcal conj vacc, serogrp A, C, Y, W-135, IM	10-18	$0	√
		19-25	$109.91	
90735	Encephalitis vacc, SQ	All ages	$116.60	
90736	Zoster vacc, SQ	60+	$148.93	
90740	Hep B vacc, ill pat, 3 dose, IM	0-18	$0	√
		19-20	$118.71	
90743	Hep B vacc, adol, 2 dose, IM	11-15	$0	√
90744	Hep B vacc, ped/adol, 3 dose, IM	0-18	$0	√
90746	Hep B vacc, adult, IM	18	$0	
		19+	$72.79	
90747	Hep B vacc, ill pat, 4 dose, IM	0-18	$0	√
		19+	$72.80	
90749	Unlisted vaccine/toxoid	All ages	Manually priced	
S0195	Pneum conj, polyvalent, IM, 5-9 yrs with no previous dose	5-9	$0	√

Appendix C - Vaccines for Children Program

Vaccines for Children Program (VCF) Introduction

Participation in the Colorado Vaccines For Children Program: Program Introduction

November 2011

The Vaccines for Children (VFC) program is a federally funded and state-operated vaccine supply program that was created on July 15, 1994. It was implemented in Colorado for the public health clinics on October 1, 1994 and for physicians in private practice on October 1, 1995. The program is intended to help raise childhood immunization levels in the United States, especially among infants and young children. The program will supply, *at no cost,* to all public health care providers and to private health care providers who agree to participate, federally purchased vaccine to be administered to children in certain groups. Approximately 60% of U.S. children may be expected to benefit from the VFC program.

The VFC program guarantees vaccine purchase and supply to all states, territories, and the District of Columbia for use by participating providers. *These vaccines are given to eligible children without vaccine cost to the provider.* All routine childhood vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are available through this program.

- Why do we need the VFC Program?

  The VFC program reduces cost as a barrier to vaccination and enables better access to health care.
  Many children are not vaccinated because their parents either do not have health insurance, or their insurance does not cover the cost of vaccines. The risk of serious illness or even death from vaccine-preventable disease is far greater for these children. However, for the many children who qualify for the no-cost vaccines provided through the VFC program, this barrier to immunization is no longer a problem.

- **Which patients are eligible?**

  Children, from birth through 18 years of age, who meet at least one of the following criteria:
  - Medicaid eligible;
  - Uninsured;
  - American Indian or Alaskan Native, or;
  - Underinsured - These patients can receive VFC vaccines at federally qualified health centers or rural health clinics, only.

- **Which patients are *NOT* eligible?**

  Children from birth through age 18 years of age, who meet at least one of the following criteria:
  - Underinsured children seen in a private physician's office (these children should be referred to either a public health clinic or a community health center to receive vaccinations);
  - Children covered by the **Colorado Child Health Plan Plus (CHP+);**
  - Children who have health insurance but whose insurance covers only a percent of the cost of one or more vaccines are still considered insured and therefore not eligible for VFC vaccines.

- How do I enroll as a provider?

  Enrolling in the VFC program is easy!

1. Log onto the Colorado VFC web-site at www.coloradovfc.com and print off a VFC Provider Pre-enrollment form. Complete the form and fax it to the VFC program at: 303-691-6118.
2. Once the pre-enrollment has been reviewed by VFC staff, you will receive a provider enrollment packet which lists our requirements for participation.
3. Read the entire packet and complete the entire enrollment form, physician signature page, and provider profile. *Please do not submit only partially completed packets as this will delay your enrollment process.* All forms must be completed to ensure you receive the amount of vaccine needed for your office.
4. Return all required forms and information to:

Colorado Dept. of Public Health & Environment
Immunization Program – DCEED-IMM A3
4300 Cherry Creek Drive South
Denver, CO 80246

fax: 303-691-6118

Colorado Vaccine for Children Program:

Welcome to the Colorado VFC Program

July 2010

Welcome and thank you for choosing to participate in the Colorado Vaccines for Children (VFC) Program! In the attached enrollment packet are several items you and your staff will need to review, as well as the New Provider Enrollment Form, the Physicians Signature Page, and the New Provider Profile Form. These pages are the actual enrollment agreement and need to be completed as thoroughly and accurately as possible. If you have questions about the program or how to complete any of the forms, please feel free to call VFC program coordinators **Nicole Ortiz or Deb Zambrano** at the Colorado Department of Public Health and Environment, **(303) 692-2650**.

Please pay particular attention to item number 12 "Type of Facility" on the New Provider Enrollment Form and use the following information to guide your response to this item.

Definitions for type of facility:

Please select the provider type that best describes your funding source from the list of definitions provided below. If you are unsure, please contact our office.

1. **Public Health Department Clinic** – any provider that is a recognized public health entity, such as local/regional Health Departments and County Nursing Services that are not recognized as FQHCs.
2. **Public Hospital** – a facility that receives federal, state, or local funding for operation.
3. **Private practices,** including solo, group, and HMO.
4. **Private hospital** – owned by a for-profit company or a non-profit organization and privately funded through payment for medical services by patients themselves or by insurers.
5. **FQHC** (Federally Qualified Health Center) is a health center designated by the Bureau of Primary Health Care (BPHC) of the Health Services and Resources Administration (HRSA) to provide health care to a medically underserved population in facilities such as those for the homeless and persons with acquired immunodeficiency syndrome (AIDS) that receive grants under the Public Health Service (PHS) Act, and "look-a-likes," which meet the qualifications, but do not actually receive grant funds. ***They also include health centers within public housing, Indian health centers, migrant, and community health centers.***
6. **RHC** (Rural Health Clinic) is a clinic located in a Health Professional Shortage Area, a Medically Underserved Area, or a Governor-Designated Shortage Area. An RHC is required to be staffed by physician assistants, nurse practitioners, or certified nurse midwives at least 50% of the time that the clinic is open, and are certified to receive special Medicare and Medicaid reimbursement.
7. **Other Public Facilities** – Clinics that receive public funding for operations. The following is a list of facilities which fall into this category:
    a. Public pre-schools/day cares/head start
    b. WIC sites (not associated with a local HD or CNS)
    c. Correctional facilities
    d. HIV/STI clinics
    e. Substance Abuse Clinics
    f. Military Health Care Facilities
    g. Public Hospital-based clinics, including university/resident clinics
8. **Other Private Facilities** – private hospital-based clinics, including university/resident clinics, privately funded day care/pre-school/head start.

Vaccines for Children Program Brochure

For more information on the VFC program, please contact Colorado Department of Public Health and Environment Immunization Program @ (303) 692-2650.
Or visit the CDC Vaccines for Children program website. http://www.cdc.gov/vaccines/programs/vfc/default.htm

What is the…

Vaccines for Children Program?

The Vaccines for Children (VFC) program guarantees vaccine is purchased and supplied to all states, territories, and the District of Columbia for use by participating providers. These vaccines are to be given to eligible children *without vaccine cost to the provider.* All routine childhood vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are available through this program.

CIP Colorado Immunization Program

What are the benefits of enrolling in the VFC program?

You can provide necessary vaccines to uninsured children and others who cannot get recommended vaccinations without financial assistance—and, you will not incur any additional costs.

You can also:

- Reduce referrals of eligible children to public clinics for vaccinations, thus allowing them to stay in their medical homes and ensuring the continuity of care.
- Save money on your vaccine purchases because you will receive publicly purchased vaccines covered by the program.
- Receive technical assistance to help improve your vaccination rates: improved record-keeping, vaccine storage and handling practices, and vaccination opportunities.

The VFC program reduces vaccination costs to parents, thereby enabling better access to health care.

Many children are not vaccinated because their parents either do not have health insurance, or their health insurance does not cover vaccinations. The risk of serious illness or even death from vaccine preventable diseases is far greater for these children. However, for the many who qualify for the no-cost vaccines provided through the VFC program, this barrier to immunization is no longer a problem.

Which patients are eligible?

Children, from birth through 18 years of age, who meet at least one of the following criteria:

- **Medicaid eligible**
- **Uninsured**
- **American Indian or Alaska Native**
- **Underinsured***

*The patient has health insurance that does not cover vaccines. (These children can **only** receive VFC vaccines at federally qualified health centers or rural health clinics.)

How can I become a VFC provider?

Enrolling in the VFC program is easy! Call the Colorado Department of Public Health and Environment (CDPHE) immunization program. Then…

1. Request a Provider Enrollment Package.
2. Complete and return the enrollment form, which lists Colorado's requirements for participation.
3. Return the Provider Profile form, as required, to ensure you receive the amount of vaccine needed for your office.

For more information on the VFC program, please contact Colorado Department of Public Health and Environment Immunization Program @ (303) 692-2650.
Or visit the CDC Vaccines for Children program website. http://www.cdc.gov/vaccines/programs/vfc/default.htm

How do I order vaccines and keep them in supply?

When you submit the Provider Profile to your state VFC program, they will send you information on ordering vaccines. You will place the order through the CDPHE VFC program, and the vaccines will be delivered according to your office schedule. Your first vaccine delivery will arrive within 30 days of ordering.

*** Medicaid enrolled providers- VFC is your one stop source for vaccines for your Medicaid enrolled Children. ***
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1246972411343

What are the VFC provider participation requirements?

By participating in the VFC program you agree to:

- **Not charge for VFC-supplied vaccine.**
- **Provide vaccine information materials as prescribed by law (required of all providers regardless of their enrollment in the VFC program).**
- **Complete the Provider Profile and enrollment form according to your state's requirements.**
- **Agree to provider site visits.**
- **Screen all children for eligibility (verification is not required).**
- **Maintain a record of the eligibility screenings.**
- **Follow the recommended immunization schedule as established by the ACIP, the American Academy of Pediatrics, the American Academy of Family Practitioners, and state law (individual medical judgment may be exercised).**
- **And you may not deny vaccinations to your VFC-eligible patients.**

Can I charge a fee for administering VFC vaccines?

Yes. However, the charge may not exceed the regional fee caps for vaccine administration, as established by the Centers for Medicare & Medicaid Services.
For more information check out the VFC FAQ's at: www.coloradovfc.com

One More Thing...

What do I need to have in order to enroll?

- An active Medicaid provider number
- High-speed internet access.
- A large capacity refrigerator/freezer dedicated to vaccine storage.

VACCINES FOR CHILDREN PROGRAM

INFORMATION FOR
HEALTH CARE PROVIDERS

Colorado VFC
VACCINES FOR CHILDREN

Vaccines Provided at No Cost
for VFC Eligible Children

Colorado Department of Public Health and Environment
Immunization Section
4300 Cherry Creek Drive South,
Denver. CO 80246.
(303) 692-2650
www.coloradovfc.com

Colorado Department of Public Health and Environment

Vaccines for Children Program FAQs

Frequently Asked Questions about the Vaccines for Children (VFC) Program

The following are questions frequently asked about the VFC Program. Please contact the VFC Program at 303-692-2650 if you have questions or need additional information.

Provider Enrollment

Which providers are allowed to enroll in the VFC program in Colorado?

- Providers who see children ages 0 through 18 years of age who fall into one of the categories below should consider becoming a VFC provider:
  - Children insured by Medicaid; and / or
  - Children who have NO health insurance,
  - Federally Qualified Health Centers and Rural Health Clinics who see underinsured children in addition to uninsured children and children on Medicaid.
- Providers are defined as:
  - Those individuals with prescribing privileges:
    - MD's and DO's
    - NP's
    - PA's
  - Clinics include:
    - Public Health Agencies,
    - Federally Qualified Health Centers
    - Rural Health Clinics
    - Private physician offices and clinics
    - School Based Health Centers
    - Hospitals
    - Urgent Care clinics

  NOTE: Since pharmacists are not eligible Medicaid providers in Colorado, pharmacies are not allowed to enroll in the VFC program at this time.

How do providers enroll in the VFC program?

- Providers must submit a completed **Provider Pre-Enrollment Form** to the VFC Program.
  - The form is available at www.coloradovfc.com ;
  - The form must be completed as accurately as possible and submitted to the VFC program via fax at: 303-691-6118.
  - After the initial screening by VFC program staff, the provider may receive a phone call to verify information.
    - Once the information has been verified, either the provider will be sent an enrollment packet via email, or:

- Provider will be asked to correct any problems before enrollment can be considered.

- Two forms must be completed by each VFC provider at enrollment; thereafter the forms must be completed and be submitted **annually** to the VFC program:
  - **Provider Profile form:**
    - It is used to evaluate vaccine orders and ensure that the amount of VFC-funded vaccine being provided is appropriate to the number of VFC-eligible children that receives care from that specific provider office.
    - For all VFC-enrolled providers, enrollment figures must be based on actual data. The Provider Profile must be updated annually.
  - **Provider Enrollment form:**
    - The Provider Enrollment form is the provider's agreement to comply with all the conditions of the VFC program.
    - This form must be signed annually.
    - The medical director or equivalent in a group practice must sign the Provider Enrollment form for the entire group.
    - ***Submission of signed Provider Enrollment forms and completed Provider Profile forms must occur annually.***

VFC Eligibility

Who is eligible to receive VFC vaccines?

- Children, from birth through 18 years of age, who meet at least one of the following criteria:
  - Medicaid eligible;
  - Uninsured;
  - American Indian/Alaskan Native, or;
  - ***Underinsured – These patients can ONLY receive VFC vaccines at Federally Qualified Health Centers (FQHCs) or rural health clinics (RHCs).***

Who is NOT-eligible to receive VFC vaccine?

Children from birth through age 18 years of age, who meet at least one of the following criteria:

- Underinsured children seen in a private physician's office (these children should be referred to either a public health clinic or a federally qualified health center to receive vaccinations);
- Children covered by the **Colorado Child Health Plan Plus (CHP+);**
- Children who have health insurance but whose insurance covers only a percent of the cost of one or more vaccines are still considered insured and therefore not eligible for VFC vaccines

What is the definition of Underinsured as it applies to the VFC Program? New 2013

Underinsured means your patient has health insurance, but the coverage doesn't include vaccines; the coverage only covers selected vaccines.

For example, if insurance covers 100% of the cost of MMR but only 50% of the cost of HPV, the child is actually considered FULLY INSURED for both MMR and HPV. If the insurance covers MMR at 100% but does **not** cover HPV, the child is considered underinsured for HPV. Co-payments and unmet deductibles (i.e., parent must pay $500 in medical expenses before insurance kicks in) do NOT meet the definition of underinsured.

How do I know if my clinic is a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC)?

- For **FQHC** verification contact: Tanah Wagenseller of the Colorado Community Health Network (CCHN) at 303-861-5165, ext. 241; or you can visit: http://www.cchn.org
- For **RHC** verification contact: Judy Hughs of the Health Facilities Division of the Colorado Department of Public Health and Environment at 303-692-2908.

Our clinic is located in a rural part of the state. Doesn't that automatically mean we have been designated as a RHC?

- Not necessarily. A clinic must meet several eligibility qualifications before being designated as a RHC. For more information contact Judy Hughs at 303-692-2908.

If an American Indian/Alaskan Native child has insurance that covers vaccines (full or partial), is the child still eligible to receive VFC vaccine?

- **Yes.** American Indian/Alaskan Native children are eligible to receive VFC vaccines regardless of insurance status. AI/AN children are always VFC-eligible. VFC is an entitlement program and participation is not mandatory for an eligible child. **For AI/AN children that have full immunization benefits through a primary private insurance, the decision to participate in the VFC program should be made based on what is financially most cost advantageous to the child and family.**

Do I have to screen for VFC eligibility every time a child comes in to the office?

- **Yes.** VFC eligibility needs to be determined and documented at each immunization encounter.

I thought underinsured children could also receive VFC vaccines? Is that correct?

- **Yes.** Refer to the question on VFC eligibility, above. Underinsured children can receive VFC vaccines ***only*** at Federally Qualified Health Centers (FQHCs) or at Rural Health Clinics (RHCs).

Are children who have Medicaid as a secondary insurance eligible to receive VFC vaccine?

- **Yes.** All children who have Medicaid as a secondary insurance are eligible for VFC vaccines. The Colorado Medicaid Program will pay the claim for the administration fee and seek reimbursement from the primary insurance carrier.

Are children enrolled in the Colorado Child Health Plan Plus (CHP+) eligible to receive VFC vaccines?

- **No.** Children enrolled in the Colorado CHP+ program are considered fully insured and are **NOT** eligible to receive VFC vaccines. In Colorado, the Title XXI Children's Health Insurance Program (CHP+) is a separate program and not a Medicaid expansion program.

Are children covered by the Colorado Indigent Care Program (CICP) eligible to receive VFC vaccines?

- **Yes.** The VFC Program considers these children to be uninsured.

Are children enrolled in a Medicaid managed care plan (such as Colorado Access, Rocky Mountain Health Plan, Denver Health, etc.) eligible to receive VFC vaccines?

- **Yes.** However, they *must* be in the plan because they are enrolled in Medicaid and **NOT CHP+**.

Can juveniles who are incarcerated and lose access to their health insurance be considered uninsured and receive VFC vaccines?

- **Yes**, an individual (under age 19) who loses access to benefits under his/her health insurance while incarcerated is considered uninsured for purposes of the VFC program.

If a VFC-eligible child who is uninsured, American Indian/Alaskan Native, or underinsured (FQHCs and RHCs only) starts a vaccine series (such as hepatitis B or HPV vaccine) at age 18, can VFC vaccine be used to complete the series after the child turns 19?

- **No.** Children are eligible to receive VFC vaccines only through age 18 regardless of the individual's immunization status (series completed or series not-completed). They ***are not*** eligible once they turn age 19.

I thought we could also give CDPHE-supplied vaccines to 19 and 20 year-old individuals enrolled in Medicaid. Is that correct?

- **No.** Starting January 2013, the CDPHE Immunization Program no longer supplies vaccines to 19 and 20 year olds enrolled in Medicaid. Immunizations are a covered benefit for Medicaid enrolled individuals beginning at age 19, and are reimbursed at a higher rate than VFC vaccines. Check the current Medicaid bulletin for more information.

Administration Fees

Are we allowed to charge for the VFC vaccines?

- **No.** You cannot charge your patients for the cost of the VFC vaccines, since you received them from the VFC Program at no cost. To do so is considered fraud and an abuse of the VFC Program.

Can we charge for administering VFC vaccines to our patients?

- **Yes.** You are allowed to charge an Administration fee for administering VFC vaccines to eligible patients.

  - NOTE this section will change as we get more information!!!!

- **Providers *CANNOT REFUSE* to administer a VFC vaccine to a VFC-eligible child in their practice simply because the parent cannot pay the administration fee.**

Why is the VFC vaccine administration fee capped at $21.68 for the non-Medicaid enrolled, VFC eligible children (those that are uninsured or under-insured, and / or non-Medicaid American Indian/Alaskan Native)?

- In 1995 the Maximum Regional charges for Vaccine Administration were established by the Department of Health and Human Services' Health Care Policy and Finance based on the geographic area of the country. They took the average national cost to administer a vaccine and multiplied it by the total Geographic Practice Cost Indices (GPCI) for each state to come up with the maximum regional charge. The GPCI included physician work, practice expenses, and malpractice. These charges will be increased to $21.68 from the current $14.74, beginning January 1, 2013, and will be in effect until the end of 2014.

We have been using VFC vaccines on fully insured patients in our office and then billing the insurance company for the cost of the vaccine and an administration fee. Is this OK?

- **No**. The national VFC Program and the Colorado VFC Program consider this to be fraud and abuse. This act is punishable by law.

Vaccine Accountability

How do I order vaccine through the VFC Program?

- To order vaccine, providers who are not using the online ordering system (VTrckS) will need to complete and submit (by fax) a **current** VFC vaccine order form to the VFC Program office.
- The current order form can be accessed at www.coloradovfc.com.
  - Current order form must include VFC PIN to be processed.
  - The vaccine order does not need to be signed by a physician.
  - Orders will not be processed if submitted on outdated forms.
  - All orders must have ***all*** current VFC vaccine inventory listed on the order form.
- Providers who are using the online tracking system (VTrckS) must order on line. Faxed orders will not be accepted in the VFC Program office.

Do I have to list my entire VFC vaccine inventory in my refrigerator and freezer when placing an order?

- **Yes**. The VFC Program and the Vaccine Tracking System (VTrckS) requires the entire VFC vaccine inventory to be reported on your vaccine order.
  - The VTrckS ordering system will not allow an order to be processed without current inventory being reported.
  - Inventory reported must include number of doses, lot #(s), and expiration date(s) for all VFC vaccine in your refrigerator/freezer for your order to be processed.

Our office is new to the VFC program and I'm faxing in my first order. When can I expect my vaccine?

- After your order is faxed to the VFC program, you will receive an email confirmation within 48 hours acknowledging receipt of your order.
- ***Contact the VFC Program at 303-692-2650 immediately, if you do not receive a return email confirmation within 48 hours.***
- Your order will then be processed, and you should expect to receive your shipment within **three (3)** weeks.

How often can I order VFC vaccine?

- VFC vaccine orders can be placed **ONCE a month**.

Routine orders submitted more frequently than monthly will not be accepted.

  - If vaccines are forgotten on the initial month's order, they will need to be submitted with next month's order.
  - Be sure to place orders with sufficient vaccine stock on hand to allow up to ***three (3) weeks for delivery*** but maintaining no more than a **30-45 day inventory**.
- It is recommended that providers keep copies of their VFC vaccine order requests.
- All vaccine orders will receive an electronic order confirmation within 48 hours of receipt.

We have a bunch of VFC vaccine that has expired. In addition, we have some VFC vaccine that the vaccine manufacturer says was ruined because it was left out of the refrigerator for several weeks. Is it OK to throw away this vaccine?

- **No.** Please follow the VFC Vaccine Return instructions for expired vaccines on the Vaccine
- Return form.

A current Vaccine Return form can be accessed from our website at www.coloradovfc.com .

- ❖ Please contact Nicole at 303-692-2334 or Nicole.Ortiz@state.co.us for instructions for returning wasted non-expired vaccine.
- ❖ All VFC vaccines that have expired or been ruined, wasted, etc., must be returned within 6 months of the expiration date to be eligible for the federal excise tax reimbursement. ***NEW 2013***

What is the Vaccine Return procedure for the VFC Program?

For vaccines that are still viable (have not been exposed to out of range temperatures):

- ❖ If you have usable viable vaccine that is going to expire, contact Nicole Ortiz at 303-692-2334 or Nicole.Ortiz@state.co.us for instructions.
- ❖ Please notify Nicole Ortiz at least **60-90 days** prior to the expiration date of any VFC vaccines.
- ❖ Vaccines that are still viable cannot be accepted for return until after the expiration date.

- ***For vaccines that have been wasted or are past their expiration date:***
  - ❖ ***Remove expired or wasted vaccines from inventory immediately!***
  - ❖ Please follow the VFC Vaccine Return instructions for expired vaccines on the Vaccine Return form.
  - ❖ A current Vaccine Return form can be accessed from our website at www.coloradovfc.com.

I received my VFC vaccine order and it's all messed up! I received vaccines that I did not order and am missing vaccines that I did order. Should I call McKesson Specialty directly?

- ❖ **No.** Immediately contact the VFC Program at 303-692-2650 for assistance with vaccine order problems.
- ❖ **Please report to the VFC Program within 2 hours of receiving the package.**
- ❖ McKesson will replace any incorrect vaccine orders within the 2 hour window.

I ordered our VFC vaccine(s) two weeks ago and still have not received them. We have a big clinic tomorrow and I am just about out of vaccine. Why the delay?

- Please allow ***three (3) weeks from the date of your order for delivery*** of your VFC vaccines.
- Remember to keep a 30-45 day supply of VFC vaccines on hand and plan your clinics so that you don't run out of vaccine before your order arrives.
- *Direct ship orders* (Varicella vaccine orders that are shipped directly from Merck) will take the entire three weeks from the date of the order until it is received in the provider office.

We have several boxes/coolers that we received vaccine in and they are starting to clutter our office. Is it OK to return these boxes to you?

- **No.** You only need to keep one or two coolers on hand for temporary storage of vaccines, if necessary. Recycle all vaccine boxes received from McKesson. **Do NOT return boxes to McKesson**.

We came back from a meeting to find our vaccine shipment sitting outside of the front door of the office, and when we opened the box, the temperature indicator was out of range. What should we do?

- You must contact McKesson at **1-877-822-7746 within 2 business hours** of receipt of the package (s) if the temperature indicator(s) is out of range.
  - Additionally, call Nicole Ortiz at 303-692-2334 or Nicole.Ortiz@state.co.us to notify the VFC Program of out of range temperature indicators.
  - McKesson Specialty Distribution has been alerted to some instances in which providers have found vaccine packages left out on their doorstep.
  - When providers have a FedEx signature release on file, it allows FedEx to drop off any FedEx package without a signature.
  - CDC and McKesson cannot override the signature release on file for McKesson shipments. You may want to consider canceling your signature release on file; however, such a cancellation will apply to all packages (vaccine and otherwise).

In the past, we always sent our expired vaccine back to CDPHE, is that OK?

- **No**. All expired or wasted vaccines must be sent back to McKesson Specialty Distribution.
- Please follow the VFC Vaccine Return instructions for expired vaccines on the Vaccine Return form.

A current Vaccine Return form can be accessed from our website at www.coloradovfc.com .

- For clarification, only wasted or expired/damaged vaccines that are in the original containers should be returned to McKesson.
- Please **DO NOT** return vaccines that have already been drawn up into syringes, as this poses a threat to workers at the distribution center.
- All VFC vaccines that have expired or been ruined, wasted, expired, etc., must be returned to McKesson **within 6 months** of the expiration date.

We have never been asked to account for vaccines that we have borrowed from VFC supplies or for VFC-eligible children when we have run low on supply. Why the change, now?

- Providers that care for VFC-eligible and privately insured children must maintain two separate stocks of vaccines, one for privately insured children and another for VFC-and/or state vaccine-eligible children. Borrowing between public and private stocks of vaccines is allowed, but must be a rare occurrence. CDC's expectation is that VFC-enrolled providers maintain adequate stocks of vaccine to administer to both privately insured and VFC-eligible children.
  - When a situation occurs which necessitates the borrowing of vaccine from VFC stock to administer to a non-VFC-eligible child or from private stock to administer to a VFC-eligible child, the VFC borrowing report must be completed.
  - ***The borrowing of vaccine must be due to unforeseen delay or circumstance surrounding the vaccine that was ordered.***
  - Similar to temperature log forms, the bi-directional borrowing form must be maintained by the provider site and must be available for review during VFC site visits.

- The VFC borrowing report is available at: www.coloradovfc.com.

What is the best way to protect my investments of VFC vaccine and my private stock vaccine in my storage units?

- The best way to protect the investments you have made in vaccine storage equipment and vaccines is to guarantee your business insurance covers the cost to replace your equipment **AND YOUR INVENTORY** in the event that the unit fails. A quick call to your agent now can prevent major out of pocket expenses later!
- The second best way to protect your vaccine investments is to purchase the proper vaccine storage equipment.

What are the current guidelines for vaccine storage equipment? New 2013

Refrigerators:

- CDC recommends the use of stand-alone refrigerator and freezer units, meaning a self-contained unit that only refrigerates or freezes and is suitable for vaccine storage. These units can vary in size, from a compact, under-the-counter style to a large, stand-alone, pharmaceutical grade storage unit.
  - **The use of dormitory or bar-style refrigerator/freezers is not allowed at any time for Vaccines for Children (VFC) program providers.**
  - The characteristics of an appropriate storage unit include:
    - Enough room to store the year's largest inventory without crowding;
    - Provide sufficient room to store water bottles in the refrigerator and frozen coolant packs in the freezer to stabilize the temperature;
    - Have a working, calibrated thermometer with Certificate of Traceability and Calibration (also known as Report of Calibration) placed in a central area inside each storage compartment (requirement); and
    - In addition, frost-free or automatic defrost cycle units are preferred.
  - Because freezing of refrigerated vaccines affects vaccine potency more than other exposure problems, it is especially important that refrigerators be selected and set up in a way that eliminates the chance of freezing vaccine.
  - Use of stand-alone units is a best practice.
  - An alternative to stand-alone units is to use only the refrigerator compartment of a combination household refrigerator/freezer unit to store refrigerated vaccines.
    - In this case, the combination household refrigerator/freezer should have separate exterior doors and thermostat controls.
    - A separate stand-alone freezer should then be used to store frozen vaccines, since studies conducted by the National Institute for Standards and Technology have demonstrated that the freezer section of combination units is not capable of reliably maintaining appropriate frozen vaccine storage temperatures.

Thermometers:

- Providers enrolled in the VFC Program are required to have calibrated thermometers in all refrigerator and freezer compartments used for VFC vaccine storage in order to monitor temperatures.
  - Each device is to be covered by a Certificate of Traceability and Calibration Testing (also known as Report of Calibration).

- Thermometer calibration must be tested annually or according to manufacturer recommendations by a laboratory with accreditation from an ILAC MRA signatory body. Laboratories that have attained this accreditation meet the requirements for traceability.
- Providers are responsible for maintaining Certificates of Traceability and Calibration Testing (also known as Report of Calibration).
- If there is not a calibrated thermometer with valid documentation (i.e., certificate) at the time of the VFC compliance site visit in any of the vaccine storage units, then action must be taken by the office to correct the situation, and the corrective action steps must be monitored by the VFC program.

- Providers wishing to enroll in the VFC program must meet the storage requirement prior to being enrolled in the program.

Must I have an alarm system on my vaccine storage unit prior to being enrolled in the VFC program?

- The CDC *does not* require VFC enrolled providers to have alarm systems on their vaccine storage units, at this time. This is individual provider preference.
  - Storage units secured with locks are also optional at this time.
- What is required is twice a day temperature monitoring and documentation on an approved temperature log (one is available at www.coloradovfc.com), every day that the clinic is open. These logs must be kept in a safe location and available for review by VFC staff, if necessary.

General VFC Information

Where can I get VFC Program forms?

- Visit the VFC Program website at www.coloradovfc.comfor all current VFC forms.

Where can I get updates about the VFC Program?

- Visit the VFC Program website at www.coloradovfc.com for current VFC memos and clinical updates. You can also sign up for E-Updates at www.coloradovfc.com

Our practice recently moved and/or we have a new VFC contact person. Who should I notify about these changes?

- You should notify the VFC Program by submitting a "***Change of Provider Information form"***.
- The form can be accessed from our web page www.coloradovfc.com

- Complete the form and fax it to 303-691-6118.
  - ***A site visit may be required once your move is complete.***
  - If we do not have the most current contact information from your provider site, we cannot ensure that you will receive up to date VFC information.

Immunization Manual Revisions Log

Revision Date	Additions/Changes	Pages	Made by
07/02/2012	*Manual Published*	*All*	*akb*
12/07/2012	*Updated Immunizations for ages 19 and 20 Information*	*All*	*akb*
12/12/2012	*Removed ACS and replaced with Xerox State Healthcare*	*All*	*cc*
12/17/2012	*Reviewed, formatted and updated TOC*	*All*	*jg*
04/23/2013	*Consolidated Electronic Billing information by referring to the General Colorado 1500 Billing Manual* *Added 2013 newly covered HCPC: 90672& 90686*	*5* *39*	*cc*
05/14/2013	*Updated TOC* *Reformatted*	*i-ii* *Throughout*	*jg*
08/30/2013	*Added NCCI PTP info* *Removed CIP* *Removed comments from Current Vaccines Provided to the VFC Program Enrolled Providers* *Updated Synagis pricing in Appendix B* *Added "female only" to HPV in Appendix B* *Changed age for influenza virus vac in Appendix B*	*8* *11* *15* *36* *37* *38*	*mh*
09/05/2013	*Updated dates*	*Throughout*	*cc*
09/20/2013	*Reformatted* *Updated TOC* *Replaced "dually eligible" with "Medicare-Medicaid enrollees"*	*Throughout* *i-ii* *18*	*jg*
02/06/2014	*Added 2% price increase in Appendix B* *Updated Synagis Bulletin to 2013* *Added NCCI Impacts on Immunizations & E/M codes*	*Appendix B* *2* *8*	*mh*
02/10/2014	*Removed reference to deleted codes 90470 & 90663* *Removed reference to added code 90654* *Revised children, adolescent, and adult immunization schedule* *Rates added for procedure codes: 90735, 90736, and 90654* *Updated FAQs*	*11* *12* *32* *39* *46-51*	*cc*
02/10/2014	*Formatted* *Revised claim example* *Updated TOC*	*Throughout* *27* *i-ii*	*jg*
03/04/2014	*Updated 90636 to $106.11; 90707 to $53.42 & 90734 to $109.91*	*34, 35 & 36*	*jg*
05/14/2014	*Updated Billing Manual for removal of the Primary Care Physician Program*	*Throughout*	*Mm*

08/11/2014	*Updated all web links for the Department's new website*	*Throughout*	*Mm*
08/29/2014	*Updated additional rate information per policy*	*7*	*MM*
11/19/14	*Changed the $6.33 & $6.46 immunization administration reimbursement rate to $6.59 per Meredith Henry's request*	*2, 6, 7*	*Mc*
12/8/14	*Removed Appendix H information, added Timely Filing document information*	*32*	*Mc*
12/11/14	*Added CPT code 90661 and 90670 and its descriptions. Added by Jeremy Oat*	*7, 35, 36*	*Mc*
12/11/14	*Updated hyperlinks*	*throughout*	*Mc*

Note: *In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above are the page numbers on which the updates/changes occur.*